

PIMA HEALTH SYSTEM  
STANDARD AND PROCEDURE

SUBJECT: Member Grievance	Administration
APPLICABLE TO: Acute Care, Long Term Care Members	Grievance System
EFFECTIVE DATE: 6/09      APPROVED BY: <i>Patricia Alvarez Hurley by signature</i>	GA-I-002
SUPERSEDES: 12/1/03, 6/04, 12/07, 06/24/09	

I. STATEMENT OF PURPOSE:

This Standard and Procedure establishes a process for a member, enrolled with Pima Health System (PHS), to make a grievance known to PHS when the member is dissatisfied with any matter other than an action.<sup>1</sup>

Statutory Basis: BBA Medicaid Managed Care Regulations 42 CFR 438 Subpart F Grievance System and AHCCCS Administrative policy.<sup>2</sup>

II. DEFINITIONS:

Action means:

- The denial or limited authorization of a requested service, including the type or level of service;
- the reduction, suspension, or termination of a previously authorized service;
- the denial, in whole or part, of payment for service;
- the failure provide a service in a timely manner;
- the failure of PHS to resolve a grievance or appeal within the timeframes provided in standard and procedure; or
- the denial of a rural member’s request to obtain services outside the PHS network when PHS is the only plan in the rural area.<sup>3</sup>

Days mean calendar days unless otherwise specified in the text.<sup>4</sup>

Grievance is defined as a concern or complaint and the means by which a member expresses dissatisfaction about any matter other than an action as defined in this section. Examples of grievance includes, but are not limited to the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee; failure to respect the member’s rights; or a member’s disagreement with an extension of the timeframe to make a decision on a new service request; or a disagreement with a denial of a member’s request to file an expedited appeal. A grievance may not be filed with AHCCCSA<sup>5</sup>. A State fair hearing is not permitted on a grievance (A.A.C. R9-34-209 and A.R.S. 36-290.01B4).

Member means a person eligible for and enrolled in the Arizona Health Care Cost Containment System (AHCCCS) and/or the Arizona Long Term Care System (ALTCS). In the context of this Standard and

<sup>1</sup> A member may file an appeal as a result of an action taken by PHS as defined in PHS Standard and Procedure: Member Appeal of Action, GA-I-001.

<sup>2</sup> In accordance with Title 9 Chapter 34 AHCCCS Grievance System; and Division of Health Care Management Policy and Procedure: Enrollee Grievance Policy dated July 1, 2004.

<sup>3</sup> Unless excepted by AHCCCSA subject to the requirements in 42 CFR 438.52 (b)(2)(ii).

<sup>4</sup> As defined by AHCCCSA.

<sup>5</sup> AHCCCSA Contracts and A.A.C. R9-34-209 do not permit a member to file a grievance with the State.

Procedure, the member's health care decision maker as defined by A.R.S. § 12-2291 is treated with the same rights and authority to amend, receive, or access the member's health information unless prohibited or excepted by state law or the Privacy Rule.<sup>6</sup>

### III. STANDARDS:

- A. A member may notify PHS of dissatisfaction in any matter and at any time following the dissatisfaction.
- B. A grievance may be submitted either orally or in writing. An oral grievance is considered received by PHS on date of communication. A written grievance is considered received by the date stamp placed on the grievance, as described in Grievance and Appeals Standard & Procedure GA-II-001, IV. Procedures, B,4,a.
- C. A provider may notify PHS of a member's grievance. If the provider is acting on behalf of the member, written permission from the member must accompany the grievance.
- D. PHS makes reasonable assistance available to a member in the grievance process by providing telephone numbers, including a toll free number, interpreter services, and TTY/TTD availability.
- E. PHS provides information on the Grievance System<sup>7</sup> to its members in accordance with PHS Standards and Procedures: Member Handbook- Acute, MS-I-0004; and Member Handbook-ALTCS, MS-I-0005. The written information describes the member's rights, the Grievance System requirements and timeframes. The information is in English and Spanish as the prevalent non-English language occurring within PHS' service area and in an easily understood language and format. PHS informs members that free oral interpretation service in any language is available by PHS and how this service may be obtained.
- F. PHS does not discriminate based on race, color, creed, religion, ancestry, marital status, sexual preference, national origin, limited English proficiency, age, sex, or physical or mental disability, in accordance with Title VI of the U.S. Civil Rights Act of 1964.
- G. Grievances are resolved within each PHS division in accordance with the division's Standards and Procedures established for handling member concerns (a grievance in the context of other PHS Standards and Procedures may also be referred to as concerns or complaints).
- H. Each grievance is acknowledged orally by the person receiving the grievance.
- I. A grievance is investigated and resolved within 10 working days<sup>8</sup> of receipt but in no case longer than 90 days.
- J. The grievance decision is made by a PHS employee with appropriate expertise and is other than the employee involved in any previous level of review or decision making in accordance with 438.406 (c)<sup>9</sup>. There is no further appeal process to the final PHS decision in the matter of the grievance.

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<sup>6</sup> State Law may prohibit or except access to medical records by additional statutes. The Privacy Standard prohibits or excepts access to records in 45 CFR§164.524.

<sup>7</sup> Grievance System refers to the term used to refer to the overall system that includes grievances and appeals handled by PHS and access to the State fair hearing process.

<sup>8</sup> Working days begins the day after the act, event or decision and includes all working days (Monday through Friday except for when those days fall on an observed holiday).

<sup>9</sup> 42 CFR 438.406 states: Each Managed Care Organization must: (c) ensure that the individuals who make decisions on grievances: 1) were not involved in any previous level of review or decision making; 2) are health professionals with appropriate clinical expertise, as determine by

- K. PHS maintains records of all grievances for a period of five years.
- L. Member information is safeguarded and released only as required by law and in accordance with PHS Standard and Procedure: Uses and Disclosure of Member's Health Information, AD VIII-0010.

#### IV. PROCEDURES:

- A. Each division is responsible for accepting, documenting, tracking, trending, and responding to the oral or written grievance in accordance with the division's own standards and procedures for resolution of member grievances.
- B. A grievance received by anyone in a division whose division is not involved with the matter of the grievance will be forwarded to the appropriate Division Manager or Supervisor for investigation and resolution.
- C. The employee receiving the grievance will notify the member of the receipt of the grievance and advise that a resolution will be provided within 10 working days but no later than 90 days. Once the grievance is resolved, the member is notified orally of the decision by the employee who makes the determination.
- D. If the grievance cannot be resolved within the 10 days after receipt of the grievance, the member is notified of the delay. The reason for the delay is documented in the grievance record.
- E. Grievances not resolved to the satisfaction of the member, after all procedural steps have been taken by the division employee handling the grievance, are forwarded to the Division's Supervisor or Manager for investigation and final resolution. If the Division Supervisor or Manager is unable to resolve the grievance due to restrictions described in III Standard "J", the grievance is forwarded to the PHS Grievance Manager or an appropriate health care professional for final resolution.
- F. Grievances regarding quality of care issues are reported to the PHS Quality Management Division's Fraud and Abuse Coordinator in accordance with PHS Standard and Procedure: Prevention, Detection and Reporting of Provider or Member Fraud and Abuse Activities, QM-VII-F; and processed in accordance with PHS Standard and Procedure: Quality Concern Resolution Related to Individual Members, QM-III-A.
- G. Grievances related to use and disclosure of member's health information are forwarded to the PHS Compliance Officer in accordance with PHS Standard and Procedure: Complaint Resolution Process Related to Uses and Disclosures of Health Information, AD-VIII-0008.
- H. When the grievance is resolved, the grievance information is logged into the division's concerns data base established for this purpose. The information maintained in the data base includes the:
  - 1. Member's name;
  - 2. AHCCCS identification number;
  - 3. Date the grievance was first received;

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the State, in treating the enrollee's condition or disease if deciding: a grievance regarding the denial of expedited resolution of an appeal or a grievance involving clinical issues.

Health professionals is defined as meaning a physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed social worker, registered respiratory therapist, and certified respiratory therapy technician. (Title 42, Part 438.2)

4. Date the oral acknowledgement was given to the member;
  5. Brief description/category of the grievance;
  6. Staff assigned for resolution of the grievance (optional);
  7. How the grievance was resolved;
  8. Date the grievance was resolved;
  9. Cause of a delay in the resolution of the grievance (if greater than 10 working days); and
  10. Date the member was notified of the resolution of the grievance.
- I. Grievances are tracked and trended by the Managers of the following divisions:
1. Member Services – Acute & ALTCS
  2. Appeals and Grievance – Acute & Appeals
  3. Home Care Support Services - ALTCS
  4. Case Management – ALTCS
- J. A summary of the tracking and trending is completed by each Manager on a monthly basis and is provided to the Compliance Office for the monthly Enrollee Grievance Report. The division summaries and grievance numbers are reviewed and aggregated to identify trends and conditions that could determine changes in standards and procedures and for the AHCCCS Enrollee Grievance Report by the Health Regulatory and Compliance Coordinator. Any changes implemented as a result of trending information are evaluated for effectiveness and a Process Improvement Project (PIP) report is completed and submitted to the Quality Management Manager.
- K. The Grievance & Appeals Manager submits a monthly Appeal Report to AHCCCS using the mandated Grievance System Reporting format (Attachment A).
- L. The Monthly Report is sent to AHCCCS by the first business day of the second month following the month being reported. The report is submitted to the following address:

Compliance Officer  
AHCCCS Division of Health Care Management  
701 East Jefferson,  
(MD #6500 for Acute MD #6100 for ALTCS)  
Phoenix, AZ 85034

- M. The report includes a summary of findings, including trending information and any corrective or process improvement actions taken.

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Enrollee Grievance Summary By Category In Descending Order	A. Total Received	B. Total Resolved	C. First Contact Resolution	D.1-10 Days	E. 11-30 Days	F. 31-60 Days	G. 61-90 Days	H. Average Time to Resolve (ATR)	I. Previous Month's ATR	J. Current Month's ATR for Previous Calendar Year
<b>Transportation</b>										
Accessibility	0	0	0	0	0	0	0	0	0	
Adequacy	0	0	0	0	0	0	0	0	0	
Availability	0	0	0	0	0	0	0	0	0	
Confidentiality	0	0	0	0	0	0	0	0	0	
Customer Service	0	0	0	0	0	0	0	0	0	
Delay in Service	0	0	0	0	0	0	0	0	0	
Miscommunication	0	0	0	0	0	0	0	0	0	
Category 8 (Blank)	0	0	0	0	0	0	0	0	0	
Category 9 (Blank)	0	0	0	0	0	0	0	0	0	
Etc. (Blank)	0	0	0	0	0	0	0	0	0	
<b>K. Summary Totals of each column</b>	0	0	0	0	0	0	0	0	0	0

Enrollee Grievance Summary By Category In Descending Order	A. Total Received	B. Total Resolved	C. First Contact Resolution	D. 1-10 Days	E. 11-30 Days	F. 31-60 Days	G. 61-90 Days	H. Average Time to Resolve (ATR)	I. Previous Month's ATR	J. Current Month's ATR for Previous Calendar Year
<b>Medical Service Provision</b>										
Accessibility	0	0	0	0	0	0	0	0	0	
Adequacy	0	0	0	0	0	0	0	0	0	
Availability	0	0	0	0	0	0	0	0	0	
Confidentiality	0	0	0	0	0	0	0	0	0	
Customer Service	0	0	0	0	0	0	0	0	0	
Delay in Service	0	0	0	0	0	0	0	0	0	
Miscommunication	0	0	0	0	0	0	0	0	0	
Potential Fraud	0	0	0	0	0	0	0	0	0	
Category 9 (Blank)	0	0	0	0	0	0	0	0	0	
Etc. (Blank)	0	0	0	0	0	0	0	0	0	
<b>K. Summary Totals of each column</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	

Enrollee Grievance Summary By Category In Descending Order	A. Total Received	B. Total Resolved	C. First Contact Resolution	D.1-10 Days	E. 11-30 Days	F. 31-60 Days	G. 61-90 Days	H. Average Time to Resolve (ATR)	I. Previous Month's ATR	J. Current Month's ATR for Previous Calendar Year
<b>Contractor Service Level</b>										
Accessibility	0	0	0	0	0	0	0	0	0	
Adequacy	0	0	0	0	0	0	0	0	0	
Availability	0	0	0	0	0	0	0	0	0	
Confidentiality	0	0	0	0	0	0	0	0	0	
Customer Service	0	0	0	0	0	0	0	0	0	
Delay in Service	0	0	0	0	0	0	0	0	0	
Miscommunication	0	0	0	0	0	0	0	0	0	
Organizational Issue	0	0	0	0	0	0	0	0	0	
Category 9 (Blank)	0	0	0	0	0	0	0	0	0	
Etc. (Blank)	0	0	0	0	0	0	0	0	0	
<b>K. Summary Totals of each column</b>	0	0	0	0	0	0	0	0	0	

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<b>Wheelchair</b>										
Power: Purchase/Rental	0	0	0	0	0	0	0	0	0	
Manual: Purchase/Rental	0	0	0	0	0	0	0	0	0	
Power: Repair	0	0	0	0	0	0	0	0	0	
Manual: Repair	0	0	0	0	0	0	0	0	0	
Other	0	0	0	0	0	0	0	0	0	
<b>K. Summary Totals of each column</b>	0	0	0	0	0	0	0	0	0	